EXHIBIT 2
DATE 2-12-09
HB 2

MONTANA
Department of Public Health & Human Services

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
PRESENTATION TO THE 2009 HEALTH AND HUMAN SERVICES JOINT APPROPRIATIONS SUBCOMMITTEE
QUALITY ASSURANCE DIVISION

CONTACT INFORMATION

The division administration and chief financial officer for the department and their contact information are:

Division Administrator	Jeff Buska	406-444-5401 jbuska@mt.gov
Deputy Administrator	Roy Kemp	406-444-2868 rkemp@mt.gov
Chief Financial Officer	Bert Freeman	406-444-9354 bfreeman@mt.gov

FUNDING AND FTE INFORMATION

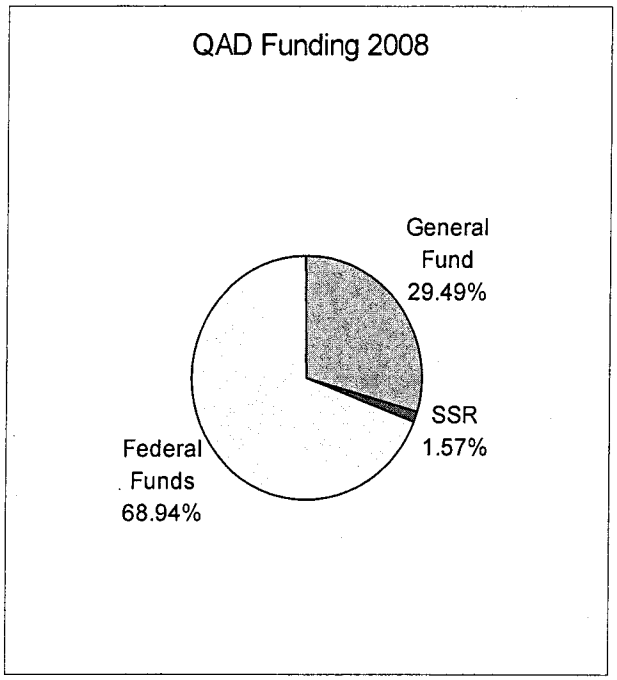
The Quality Assurance Division budget for the 2009 biennium (fiscal 08-09) is $17.4 million dollars and $18.3 million for the 2011 biennium (fiscal 10-11). The QAD budget consists primarily of personnel services and operating costs to support the required workforce to fulfill the mission of the division and that of the department.

	2009 Biennium	2011 Biennium	% of Total	Difference	% of Difference
FTE	120.48	121.23		0.75	
Personal Services	13,238,360	13,460,153	73.5%	221,793	25.9%
Operating	3,117,373	3,741,336	20.4%	623,963	72.9%
Equipment	15,145	15,000	0.1%	(145)	0.0%
Grants	1,090,077	1,100,760	6.0%	10,683	1.2%
	17,460,955	**18,317,249**	**100.0%**	**856,294**	**100.0%**
General Fund	5,212,579	5,595,145	30.5%	382,566	44.7%
State Special Fund	272,060	495,620	2.7%	223,560	26.1%
Federal Fund	11,976,316	12,226,484	66.7%	250,168	29.2%
	17,460,955	**18,317,249**	**100.0%**	**856,294**	**100.0%**

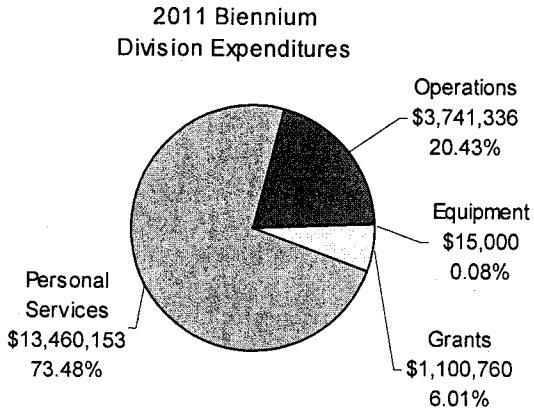
The funding for the division includes state general fund, state special revenue funds, and combination of approximately 12 sources of federal funding. The primary source of federal funding pertains to Medicare and Medicaid under Titles XVIII and XIX of the Social Security Act.

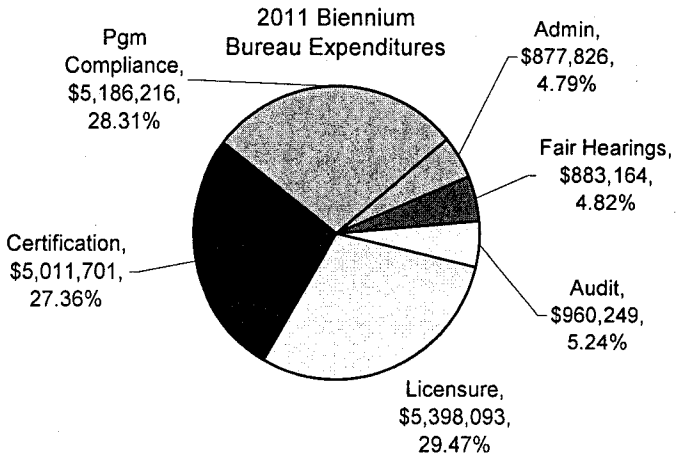
State Fiscal Year 2008
$2.4 Million General Fund (29.49%)
$131 Thousand State Special (1.57%)
$5.7 Million Federal Funds (68.94%)

State licensing programs for health care facilities and child care are heavily dependent on general fund appropriations. Other programs in QAD are funded with federal dollars that include a state matching requirement under Medicaid. This is typically provided at 50/50, and some programs are funded at 75/25.



2011 Biennium Funding
- FY 2010 $9,150,703
- FY 2011 $9,166,546





QAD operates the states' Medical Marijuana registry. The registry fee is deposited in a State Special Revenue account and QAD receives an appropriation from this account for operating the Medical Marijuana Program (MMP). This program is experiencing significant growth in 2008-2009 and is expected to continue into the next biennium. (See Attachment F).

OVERVIEW OF THE QUALITY ASSURANCE DIVISION (QAD)

The role of the Quality Assurance Division (QAD) is to protect the safety and well-being of Montanans by monitoring and ensuring the integrity and cost-effectiveness of programs administered by the department. The division fulfills this role by:

- Licensing and/or certifying health care, child care, and residential services;
- Detecting and investigating abuse and fraud committed by recipients of Temporary Assistance to Needy Families (TANF), Medicaid and Food Stamp programs;
- Monitoring recipient overpayment claims for TANF, Medicaid and Food Stamps;
- Performing federally mandated quality-control reviews of the Medicaid and Food Stamp programs;
- Reducing Medicaid costs by identifying other insurers or parties responsible for paying a beneficiary's medical expenses;
- Providing independent audits for DPHHS programs;
- Conducting retrospective reviews of Medicaid provider claims;
- Providing independent fair hearings for clients and providers participating in DPHHS programs;
- Monitoring and evaluating Health Maintenance Organizations for quality assurance and network adequacy;
- Maintaining a certified nurse aide registry, and approval and monitoring of nurse aide training programs;
- Operating the Certificate of Need program;
- Ensuring department compliance with the federal Health Information Portability and Accountability Act (HIPAA), and
- Operating the Medical Marijuana Registry.

QAD FTE - 120.7

- Helena Based 88.5 FTE
- Field Offices 32.2 FTE

The division has field offices in Anaconda (2 FTE), Billings (13 FTE), Bozeman (.75 FTE), Great Falls (3 FTE), Havre (1 FTE), Kalispell (1.45 FTE), Miles City (2 FTE), and Missoula (9 FTE). QAD utilizes telework for 5 Helena based FTE in the following locations: Bozeman (2), Hamilton, Hinsdale, and Lincoln.

The Quality Assurance Division is organized into five bureaus with financial administration technical support staff:

Audit Bureau – (Carol Bondy, Bureau Chief) 7.0 FTE Helena (Attachment A)

- Audit the compliance and financial stability of health and human service providers.
- Audit the efficiency and compliance of DPHHS internal work processes.
- Review A-133 Audits to provide DPHHS managers with financial and compliance information for program management.
- Prevent and pursue fraud allegations.

Certification Bureau – (Jill Caldwell, Bureau Chief) 24.0 FTE Helena - 7.0 FTE Field (Attachment B)

- Health Care Facility Certification for Medicare & Medicaid.
- Assist new facilities in obtaining certification.
- Conduct on-site surveys to ensure compliance with federal health and life safety code regulations and recommend enforcement procedures.
- Conduct complaint investigations.

- Approve Nurse Aide Training programs and maintain Certified Nurse Aide Registry.
- Conduct surveys and maintain data base for clinical laboratories.

Licensure Bureau – (Becky Fleming-Siebenaler, Bureau Chief) 13 FTE Helena – 18.2 FTE Field (Attachment C)

- State licensure of health care, residential care and community residential care providers.
- State licensure, or registration, of child day care facilities.
- Facility inspections for licensure, renewals, and complaints.
- Operate Certificate of Need (CON) Program.
- Monitor and evaluate HMOs for Quality Assurance and Network Adequacy.
- Operate Medical Marijuana registry.

Office of Fair Hearings – (Bridgitt Erickson, Bureau Chief) 6.0 FTE Helena (Attachment D)

- Adjudicate issues related to public assistance, child care, and public health activities.
- Research statutes, rules, and court cases to determine the applicable law and apply the law to the facts to reach conclusions of law.
- Review and analyze medical information, health policies, medical records, property records and financial documents.
- After weighing the evidence and evaluating the testimony, prepare and issue written decisions that are binding, unless appealed to the Board of Public Assistance, Director or district court.
- Conduct Informal Dispute Resolution conferences for long term care facilities and render recommendations after determining the outcome of each disputed deficiency and the scope and severity level based upon the factual basis of the citations and the application of federal and state laws governing the survey and certification processes.

Program compliance Bureau – (Russ Hill, Bureau Chief) 28.5 FTE Helena – 12.0 FTE Field (Attachment E)

- Recover overpayments to clients for Medicaid, TANF, and SNAP.
- Audit SNAP, Medicaid and CHIP cases to assess accuracy of eligibility determination and approved benefits.
- Monitor use of the Medicaid program by providers and recover overpayments.
- Identify and coordinate with other parties responsible to pay expenses for Medicaid recipients.
- Responsible for overall compliance by DPHHS with the Health Insurance Portability & Accountability Act (HIPAA).

2009 BIENNIUM GOALS AND OBJECTIVES

2009 GOALS AND OBJECTIVES TRACKED BY THE INTERIM FINANCE COMMITTEE

Goal - Third Party Liability - Take all reasonable measures under the Social Security Act to ascertain the legal liability of "third parties" for health care items and services provided to Medicaid recipients.

Measures

1. Evaluate and improve the systems for the identification of Medicaid recipients with Medicare and/or other health insurance.
2. Maintain the number of people with Medicaid and Medicare (Dual Eligible's), subject to change in Medicaid enrollment.
3. Increase the number of Medicaid recipients with other health insurance 1% per year.
4. Ensure Medicaid health care costs are avoided by requiring other health insurance companies to pay before Medicaid.
5. Increase the Medicaid cost avoidance per person with Medicare and/or other insurance by 5% per year.

2009 Biennium Milestones

- Cost Avoidance (Target 4% Increase) - Medicaid (people with Medicare and/ other insurance) increased by 4% SFY07 $117,049,202, SFY08 $121,776,606
- Average monthly dual eligible (Target Maintain) - Number of dual eligible clients (SFY07 15,487 & SFY08 15,792) increased by 2%. Cost avoidance per dual eligible (SFY07 $6,231 & SFY08 $6,552) increased by 5%.
- Medicaid recipients with other health insurance (Target Increase 1%) - Number of clients (SFY07 5,351 & SFY08 4,752) decreased by 11%.
- Cost Avoidance per person (Target Increase 5%) - Cost avoidance per person with insurance (SFY07 $3,839 & SFY08 $3,853) increased by .3%.

QAD is focusing on systemic improvements for identifying Medicaid recipients that have other health insurance with the emphasis on the new discovery of insurance process we have implemented. Effective September 1, 2008 the department assumed responsibility for this function from our contractor (ACS State Healthcare). QAD identified systemic improvements that could be implemented by focusing efforts on discovery of new insurance and timely updating of the information into the claims processing system (MMIS).

QAD staff will timely monitor claims that have been processed in MMIS that identify third party information. This information will be immediately verified with the insurance carrier and added to the client record in the Medicaid eligibility system. We anticipate that focusing efforts in this area in an efficient and effective manner will result in the increase of the number of clients with identified third party insurance. In addition, by implementing this function, we expect to see an increase in the cost avoidance figures for Medicaid benefits, and a decrease in the number of claims that require pay and chase efforts by the department. We expect to be able to meet or exceed our goal for the next fiscal year by increasing our Medicaid cost avoidance per person by 5% or more.

Goal - Fair Hearings - Provide timely and impartial hearings and decisions for adversely affected parties disputing facts and/or law involving DPHHS administered programs.

Measures

1. Maintain fair and impartial Office of Fair Hearings decisions within state and federal statutory guidelines.
2. Maintain a 90% timely decision percentage for all administrative hearing decisions within the statutory timelines each fiscal year.

2009 Biennium Milestones

SFY	Hearing Decisions	Decisions Timely	Percent Timely
2003	450	308	68%
2004	376	303	81%
2005	403	314	78%
2006	545	497	91%
2007	583	537	92%
2008	529	516	98%
2009	204	196	96%

Goal - Fair Hearing Informal Dispute Resolution (IDR) - Provide timely and impartial Informal Dispute Resolutions (IDR) conferences and recommendation for long term care facilities disputing DPHHS-cited deficiencies.

Measures

1. Maintain fair and impartial Office of Fair Hearings IDR decisions within state guidelines.
2. Maintain a 90% timely decision percentage for all IDR recommendations within statutory timelines for the calendar year.

2009 Biennium Milestones

Calendar Year	IDRs Requested	IDRs Withdrawn or Denied	IDR Opinions	Timely Rendered	Percent Timely
2005	20	2	18	5	28%
2006	24	9	15	13	87%
2007	19	8	11	10	91%
2008 *	13	3	8	3	37.5%

* Of the two cases outstanding for 2008, one case has been closed in accordance with the timelines and as of February 2008 one case remains outstanding. This case is expected to be timely.

Due to temporary staff shortages (as a result of vacations and sick leave & retirement), the IDR Presiding Officer was assigned to conduct administrative hearing cases in the capacity of a Hearing Officer. This adversely affected the timeliness of rendering IDR opinions. To correct this situation, a number of hearing appeals are being referred to the Department of Justice, Agency Legal Services Division. Office of Fair Hearings is fully staffed and priority will be restored to the IDR caseload.

Goal PERM - Implement the Payment Error Rate Measurement (PERM) process as required by CMS.

Measures

1. Complete the required number of reviews pursuant to the federal guidelines.
2. Monthly review of 84 active cases and 34 negative cases for Medicaid and CHIP.
3. Complete the cases in 100 days from the date sampled and report the results to CMS.

2009 Biennium Milestones

- The required number of Payment Error Rate Measurement (PERM) CHIP and Medicaid cases have been completed pursuant to the federal guidelines.
- 1416 Eligibility Reviews have been completed: 1008 Active Cases have been completed and 408 Negative Cases completed.
- For the PERM review period, 93% of all cases were completed within 100 days and results were reported to CMS.

Implementation of the Payment Error Rate Measurement (PERM) process continues to be successful and QAD has completed the required number of reviews within the Federal timeliness guidelines. Aggressive internal goals to complete Medicaid and CHIP eligibility cases within 100 days has been challenging and 93% of the cases were completed within this time frame. The 7% not completed within the internal state goal of 100 days has been a direct result of new staff, training and implementation of the new process. 100% of the cases were completed within 120 days. This is well within the Federal guidelines of having all cases completed within 150 days.

ACCOMPLISHMENTS DURING THE 2009 BIENNIUM

Accomplishments

SJ7 Study

The Quality Assurance Division completed a study and report for the 61st Legislature as required under Senate Joint Resolution 7 (SJ7), as enacted by the 60th Legislature. SJ7 requested the Department of Public Health and Human Services and the Department of Justice to examine a requirement of criminal background checks for direct-care workers. DPHHS was the lead agency in this effort and conducted the study during the interim and utilized a diverse workgroup to address the provisions of the resolution. This report will be a useful tool for legislators in addressing public policy debates or legislation that would require criminal background checks for direct-care workers.

OFH Website

The Office of Fair Hearings and Technology Services Division completed the construction of a website to which all final hearing decisions are posted for public access. This website can be searched by year, program, and issue for obtaining de-identified hearing decisions for purposes of research and information. This website is a useful tool for clients, providers, attorneys and agency staff as a resource for information and resulted in administrative efficiencies in the Office of Fair Hearings. The on-line availability eliminates the need to submit written requests for information on a specific case or group of cases and the administrative requirements to respond to those requests. This results in administrative savings and efficiency for the office and a useful resource for the public.

PERM Implementation

The 60th Legislative session authorized funding and staff for the Quality Assurance Division to implement the Payment Error Rate Measurement (PERM) program. The division successfully implemented the program as required by the Centers for Medicare and Medicaid Services (CMS). The purpose of PERM is to produce national error rates for Medicaid and the State Children's Health Insurance Program (SCHIP).

Under PERM, reviews will be conducted in three areas:

(1) fee-for-service (FFS) claims,
(2) managed care claims, and
(3) program eligibility for both the Medicaid and SCHIP programs.

CMS developed a national contracting strategy for measuring the first two areas. Currently, QAD is coordinating communications, documents, and data with the Federal contractors for their claim reviews.

For the program eligibility reviews, QAD hired staff in September and October of 2007 and began conducting eligibility reviews in November 2007. The State was required to conduct the eligibility reviews because DPHHS administers the Medicaid and SCHIP eligibility. QAD has finished the Medicaid and CHIP eligibility reviews for the 2008 PERM year (October 2007-September 2008). Upon completion 708 Medicaid cases and 708 CHIP cases have been reviewed. Beginning in January, PERM staff will begin audit reviews on three projects; Nursing Home, Medically Needy Incurrent and Developmental Disabilities cases.

Third Party Liability (TPL)

QAD manages the Medicaid Third Party Liability (TPL) program that has the responsibility for ensuring that Medicaid is the payer of last resort on healthcare claims for services provided to Medicaid clients. This is accomplished through the following activities:

- Coordination of benefits with Medicare and other health insurance.
- Operating the Medicare buy-in program to pay for Medicare premiums and coordination of Part D benefits and clawback payments for eligible low-income senior citizens.
- Operating the Health Insurance Premium Payment program for Medicaid recipients who need assistance in maintaining their health insurance.
- Collection of Medicaid funds from other insurance, settlements, liens, estates and other sources of funding.

During the last biennium QAD completed numerous system and procedural changes to improve the accuracy and timeliness of activities. Through automation and efficiency the section increased savings for the Medicaid program by $27.5 million from SFY 2006 to 2008. This is an important function for the Medicaid program because continued improvement and efficiencies in this area contribute to the sustainability of the Medicaid expenditures and continued services for needy Montanans.

State Survey Agency & CMS

The Certification Bureau successfully satisfied the performance requirements of the Centers for Medicare and Medicaid Services (CMS) Mission and Priority Document for Federal Fiscal Year 2007. The requirements are issued with the state contract with CMS and direct the scope of work for the Bureau. The Bureau met the federal performance standards for nursing homes in areas of frequency of data entry,

documentation of survey deficiencies, timeliness of EMTALA (Emergency Medical Treatment and Active Labor Act) investigations and adherence to federal conditions of participation. The Bureau found challenges in meeting the requirements of timeliness of standard nursing home surveys, non long term care facility surveys and complaint investigation surveys. The primary reason for not meeting the requirements was inadequate staffing due to difficult to fill positions and an aging (retiring) workforce.

Certified Nurse Aide (CNA) Registry

The Certification Bureau updated and enhanced the Certified Nurse Aide electronic registry. The Bureau also improved the current registry website feature to make it more user friendly, combining it with other e-government features from other state agencies. The registry is now available on demand to those using the state's Licensee Look-up feature on mt.gov 24 hours a day, 7 days a week. This feature interacts with databases from the Department of Labor and Industry, the Office of Public Instruction and the Department of Commerce to list details of individuals who hold professional licenses in Montana. This new feature has reduced the number of telephone calls while improving customer service by making the information available 24/7.

2011 Biennium Goals and Objectives

The 2011 goals and objectives for QAD are centered on three of the governor's Guiding Principles: Sustainability, Efficiency, and Effectiveness.

Department of Public Health and Human Services Quality Assurance Division	
Goals and Objectives for the 2011 Biennium Submitted September 15, 2008	
GOAL: Continuous improvement in the Department's efforts to protect the health, safety, and well being of Montanans by: o Maintaining an environment that promotes Montana health care facilities, youth care facilities, child care facilities and facilities serving individuals with physical and developmental disabilities to be in compliance with applicable laws and regulations. o Provide program integrity oversight, audit, and impartial decisions that enhance the effectiveness and efficiency of department operations.	
Objective	**Measurement**
• Perform licensure inspections and certification surveys for the respective facilities and providers as established within the applicable state and federal laws.	o Perform licensure inspections and issue licenses for the respective facilities as established within state law. o Perform all recertification surveys for certified health care facilities according the Federal and state schedules.

Objective	Measurement
	o Perform initial certification surveys for all new health care facilities requesting the same within 3 weeks of the request. o Investigate complaints regarding health care facilities; youth care facilities; child care facilities; and facilities caring for persons with physical or developmentally disabilities in a timely manner according to their severity but in less than 45 working days from their receipt.
• Provide program integrity oversight and maximize cost avoidance and recoveries for applicable agency programs in accordance with state and federal laws.	o Take all reasonable measures under the Social Security Act to ascertain the legal liability of "third parties" for health care items and services provided to Medicaid recipients. o Disqualify individuals from TANF and/or Food Stamps that are found guilty of program violations, and collect overpayments. o Ensure a positive return on investment for the SURS unit for biennium. o Perform quality control audits and reviews of client eligibility for Medicaid, Food Stamps and CHIP, and work with eligibility staff to ensure compliance with state and federal regulations.
• Conduct independent audits of agency programs and services and provide agency management with evaluations of internal work processes.	o Conduct independent audits of DPHHS work processes and service providers to determine whether sound financial management is achieved and program goals are met. o Assist in the prevention and deterrence of fraud through fraud audits, providing internal control expertise to department management, and reporting fraud and theft.
• Provide timely and impartial administrative hearings and decisions	o Maintain fair and impartial Office of Fair Hearings administrative and IDR

Objective	Measurement
and Informal Dispute Resolution (IDR) conferences and recommendations.	decisions within state and federal statutory guidelines. o Maintain a 90% timely decision percentage for all administrative hearing decisions and IDR recommendations within the applicable statutory timelines.

QAD DECISION PACKAGES

The Quality Assurance Division is responsible to monitor programs authorized by various provisions of Titles 33, 50, 52, and 53, Montana Code Annotated. Several of these programs are monitored for Medicare and Medicaid based upon the authority originating in Titles XVIII and XIX of the Social Security Act and Title 42 of the Code of Federal Regulations.

QAD business functions are based upon these regulatory requirements and regulations. This requires sufficient manpower and supportive systems to maintain our ability to provide core business services. The budget and decision packages for the 2011 biennium support this effort.

DP 80001 - Annualization FTE Utilization (Page B-152, LFD Budget Analysis for the 2011 Biennium) - The executive proposes increased federal support of $27,501 for 0.25 FTE, funded through the Montana Rural Hospital Flex Grant, to manage increased functions and oversight.

This request is to increase one position from .75 FTE to 1.00 FTE. This increase is currently approved as a modified position to manage increased functions and oversight of the Montana Rural Hospital Flex Grant and the contract with the Montana Health Research and Education Foundation (MHREF). This FTE increase is funded by this Flex grant.

DP 80002 - FTE for Medical Marijuana Program (Page B-153, LFD Budget Analysis for the 2011 Biennium) - The Quality Assurance Division is requesting an additional 0.50 FTE for the Medical Marijuana Program (MMP) to address the increased workload MMP is experiencing due to significant growth in the number of approved patients and caregivers in the program. This request is for $50,092 in state special funds.

(See Justification Page B-153 through page B-155)
(See Attachment F)

DP 80006 - Address CMS Task Orders and Workload (Page B-153, LFD Budget Analysis for the 2011 Biennium) - This request is for $118,000 in additional federal funding for the biennium for the Certification Bureau to meet the workload demand outlined in the Centers for Medicare and Medicaid Services (CMS) task orders addressing increased technology requirements, increased emergency preparedness planning, and increased number of health care facility surveys.

This is the increase that CMS included in the State Survey Agency budget for FFY 2009, and it is expected that this level of effort will continue into the next biennium.

The Certification Bureau is the State Survey agency for Montana and is required to accomplish all surveys as outlined by CMS, see Attachment B. In addition, QAD is required keep all surveyors trained and certified. CMS is invested in updating surveyor training both for generalists and specialties and this training is often conducted out of state.

Example of significant changes that drive the increases in the 2010-2011 budget proposals are as follows:

- Increase in the Tier 2 targeted sample size of ambulatory surgical centers from 5% to 10%. If this increase in workload is not accomplished, CMS will reduce the budget funds allocated to the state.
- Quality measure of the timeliness of complaint investigations performed at ambulatory surgical centers is now a performance standard for the State Agency. This means that if the work is not done, the State will be penalized.
- The number of complaints that are investigated has not significantly increased, but the seriousness of those complaints has increased. During Federal fiscal year 2008, almost 25% of all complaints required an investigation in ten days or less, and approximately 10% of all required an investigation within 5 days. Since the Bureau does not have a separate complaint investigation staff these investigations alter the regularly scheduled surveys. This in turn, puts the state agency in a situation where it struggles to meet the workload demands of the MPD. Not meeting those workload demands results in a financial penalty. Not meeting the timeliness component of complaint investigations may also result in a financial penalty. The Agency anticipates contracting with independent surveyors to complete workload.
- CMS has introduced several new survey instruments and processes for selected facility types, and CMS requires that surveyors who survey these facilities receive the training. Most of the CMS training is done in Baltimore, New York or California. This increases travel costs to the state agency.

DP 80007 - PERM Funding (Page B-153, LFD Budget Analysis for the 2011 Biennium) - The Payment Error Rate Measurement (PERM) audits are performed every three years and take approximately two years to complete. In the third year of the cycle, staff do not perform PERM related reviews. FY 2010 is the third year of the current PERM cycle. PERM staff will conduct reviews of eligibility for high cost, complex Medicaid cases in FY 2010. In FY 2011, PERM staff will begin the second PERM review for both the Medicaid and CHIP programs. This decision package provides for the changes in funding due to the shifting duties of the staff. The executive proposes an increase of $68,929 in general fund and an offsetting reduction in federal funds over the biennium and asks that the funding be nonrestricted.

Montana's PERM year is federal fiscal year 2008 (October 1, 2007 – September 30, 2008), and our next PERM cycle is federal fiscal year 2011 (October 1, 2010 – September 30, 2011), thus the reference to the three year cycle. For the next biennium this PERM cycle encompasses approximately September 2010 through June 2011 or 10 months of fiscal year 2011. For budgeting purposes, DPHHS begins the PERM cycle one month prior to the PERM year to conduct training and planning for staff, as well as activities that are required for submitting and approval of sampling plans with CMS.

Therefore, for the beginning of the 2011 biennium until the beginning of the next PERM cycle (July 1, 2009 through approximately August 31, 2010), PERM staff will be working on special projects related to Medicaid. This focus was approved during the 2007 legislative session, after consideration by the Health and Human Services Appropriations Subcommittee. The proposed Medicaid focus in between PERM years includes conducting reviews of eligibility on

three project areas: Nursing Home, Medically Needy/Incurment and Developmental Disabilities cases. QAD began the planning for these reviews in December 2008 and is currently conducting these focused reviews.

In addition, PERM staff has completed the 2008 PERM eligibility reviews and are working with CMS PERM contractors on the Medicaid and CHIP claim audits which are expected to be completed by the end of July 2009. QAD participated in orientation meetings with Health DataInsights (HDI) in November and the onsite audits started on January 26th at ACS, and will continue with Blue Cross and Blue Shield on February 2nd.

This change in scope removes the need to fund some of the QAD staff with CHIP funding at 80/20 from July 1, 2009 through approximately August 31, 2010. The staff will switch focus and perform Medicaid reviews which are funded at 50/50. Therefore, this change creates the need for the decision package to account for the changes in funding. This proposal requires more general fund ($68,929) to move from 80/20 to a 50/50 match rate. This increase in general fund has an offsetting reduction in federal funds over the biennium.

The reason the division is requesting that this decision package be non-restricted is so we are able to adjust for changes in the workload and timing of the PERM activities. Throughout this PERM year the department has experienced challenges and delays with PERM activities. Some of the issues have been on the part of CMS and some from DPHHS and our ability to respond to information requests and programming. In addition, we see the opportunity to provide cross training with our Medicaid Eligibility Quality Control (MEQC) staff and create opportunities to distribute resources appropriately to address recruitment and retention issues.

More on PERM – (See Attachment G)

DP 80008 - Rent Funding (Page B-153, LFD Budget Analysis for the 2011 Biennium) - This decision package addresses rent increases that are built into the lease agreements for staff offices around Montana.

All of the office space utilized by QAD is in buildings that are under lease arrangements. These leases provide for 2%-3% increases in rent from year to year. This decision package request funding to account for this cost of doing business.

DP 80009 - Lien and Estate Funding (Page B-155, LFD Budget Analysis for the 2011 Biennium) - The 2007 legislature approved $366,160 in one-time-only funding to finalize 76 lien and estate recovery cases that had been outstanding for many years. In FY 2008, the agency closed 53 cases and collected over $616,000. As of October 2008, there are 62 cases outstanding. The executive proposes continuing this program and requests $183,000 in state special revenue and $183,000 federal funds for the biennium.

The Department continues to have outstanding lien and estate cases that need legal assistance. As of December 2008 QAD has 53 cases outstanding in our inventory of lien and estate cases. QAD has 41 cases outstanding that pertain to the basis of the request from the 2007 legislative session.

In the 2009 biennium request, QAD identified 76 cases that needed legal services from the Department of Justice (DOJ). The actual number of cases after approval and implementation was identified to be 87 cases. This count included old cases that were handled by a previous contractor and were assumed by QAD when the contract was terminated at the end of SFY 2003. In addition QAD continues to receive new cases in our management of the program. Some cases are resolved through the normal course of business and some require additional

legal assistance. To date QAD has referred 67 additional cases to DOJ for assistance, with 12 cases that are still open and outstanding.

This project has been extremely successful in the resolution of lien & estate cases. The combination of old and new cases that have been resolved since we began this project in SFY 2007 is 103 cases, with a recovery of over $1.5 million dollars. During SFY 2008, 53 cases were closed with a recovery of $616,539.

The lien and estate program will continue to identify new cases on an ongoing basis that would benefit from this legal assistance from the DOJ. This legal assistance enhances our ability to identify and close cases in a timely manner. We continue to pursue and attempt to close old cases that have the potential for recovery for the state, however due to the age of those cases resolution is more legally challenging.

Including old and new cases, QAD has a total of 53 cases still outstanding as of December 31, 2008. The number of new cases each year is dependent on a number of factors as the program reviews approximately 1800 deaths in the Medicaid caseload annually. The extent of the cases identified for legal assistance depends on the circumstances of individual client assets at the time of death and whether the estate is going to be settled in probate or not, or whether a trust is involved. The program is currently reviewing approximately 20 cases that will require additional legal assistance that have not yet been referred to DOJ.

The estimate used for purposes of this decision package reflects assumptions of closing approximately 40 cases per year. During SFY 2008 QAD and DOJ closed 53 cases, and as of December 31, 2008, six months into SFY 2009, 19 cases have been closed with collections of over $315 thousand dollars for Montana. We expect to reach closure of 40 cases for SFY 2009 and plan to resolve more of the old cases we have in our inventory.

For the next biennium we estimated a similar caseload as previously used last legislative session. Although our actual costs per case closed ($1,962) is less than our estimates ($4,577), we do expect increased costs in the next biennium. The budget request reflects this potential for increased costs; however it depends on the need to incur costs such as property-related expenses for repairs, utilities, lawn cleaning, ongoing maintenance and insurance. In addition, QAD was recently awarded a grant to improve the operations of the Lien and Estate process. One of the anticipated results of these improvements is an increase in the number of cases identified for recovery. As more cases are identified it is highly likely that the number of cases that will be referred to DOJ for assistance will also increase.

The bottom line is that as a result of incurring these expenses, it is anticipated the Department will recover funds that would not otherwise be recovered.

More on Lien & Estate – (See Attachment H)

DP 8101 – Increase 4% Vacancy Savings to 7%. The December 15th amendments to the Executive budget increased the applied vacancy savings rate from 4% to 7%. There is a 4% vacancy savings built into agency adjusted base budgets. This decision package includes the additional 3% vacancy savings.

The additional vacancy savings amounts to $89,297 and $88,251 in general fund savings in SFY 2010 and 2011 respectively. The total savings with matching of federal funding is $215,620 and $216,102 for SFY 2010 and 2011 respectively.

SIGNIFICANT ISSUES

A brief list of issues that may present obstacles or challenges to ensuring achievement of the performance measurements for the 2011 goals outlined above. More detail on significant issues is found in individual program write ups.

Vacancies

- Recruitment and retention of qualified candidates has been a significant issue for the Program Compliance and Certification Bureaus.

Systems Development – Enhancements

- TPL - Funding for system enhancements is a barrier for this area. Many of the tasks are done manually and could be automated, thereby improving efficiency and increasing collections of costs avoided.
- Lien & Estate – Funding for systems development and enhancements to address results of the Medicaid Transformation grant to improve the operations of the Lien and Estate process.

MMP Staffing and Workload

LEGISLATION - SENATE BILL 82

The Department of Public Health and Human Services (DPHHS) operates the Medicaid program, a requirement of operating the Medicaid is that the State must coordinate with other liable third parties to ensure Medicaid is the payer of last resort. There are aspects of the current laws that require clarification and change to ensure efficient administration. Below is an outline of the requested changes:

Change: Eliminate the reference to county in MCA 53-2-612.

Rationale: The county references pertain to medical programs under general assistance programs and medical programs for state assumed counties. The MCA was established several years ago for Medicaid benefit recoveries and benefit recoveries for these county medical programs. Since county general assistance programs and medical programs under state assumed counties no longer exist, the county references in the code are no longer needed.

Change: Modify MCA 53-2-612 to add language indicating Medicaid can only collect from the portion of a client's judgment or settlement that is related to medical expenses.

Rationale: The U.S. Supreme Court ruled in Arkansas v Ahlborn that Medicaid agencies can only collect Medicaid expenses from the medical portion of any judgments or settlements. DPHHS made operational changes to incorporate this requirement, and the Montana Code Annotated now needs to be changed to reflect this requirement.

Change: Add Financial Institutions to the list of entities required to cooperate with Medicaid in the settlement of Estate cases.

Rationale: Medicaid recipients are allowed to retain personal funds up to a limited amount ($2,000). State and Federal laws require that those personal funds be paid to the State Medicaid Agency (DPHHS) upon the death of the recipient. Typically these personal funds are administered by the nursing facility however some personal funds are maintained by guardians or family members using private bank accounts. Currently, Financial Institutions with those

private bank accounts are not required to remit those funds upon death of the Medicaid recipient. This has caused numerous problems with compliance regarding the federal law when funds are not returned. Sometimes these funds become unclaimed funds and are not remitted to DPHHS. This change will help solve this problem.

Change: Exclude, from Estate Recovery, medical assistance paid on behalf of Medicaid recipients under Medicare Savings Plans. This includes Medicare premium payments and payments for coinsurance and deductibles on Medicare crossover claims covered under the Medicaid program.

Rationale: To implement changes related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Change: Modify MCA 53-6-167 to clarify that the department is not required to initiate probate in order to collect under this section.

Rationale: DPHHS was involved in a recent legal action related to this topic and prevailed. This change codifies the courts' decision.

Change: Modify the hardship provisions in MCA 53-6-178 and 53-6-180 to eliminate inconsistencies with other sections of the MCA.

Rationale: There are current inconsistencies related to the provision of hardship waivers under the Lien and Estate recovery programs. This change eliminates those inconsistencies in an effort to improve efficiency in administration.

DP-80010 - Data automation tweaks.
80011 - CHIMES enhancement

EXHIBIT 2
DATE 2/12/09
HB 2

Attachment A

AUDIT BUREAU
2009 LEGISLATIVE SESSION FACT SHEET

The purpose of the Audit Bureau is to conduct independent audits of department work processes and DPHHS contractors to ensure sound financial management and proper program performance. Audit results are reported to department management to enhance Federal and State program management. Audits are an essential tool to assess financial management, proper internal control, and contract and regulatory compliance.

The Audit Bureau is responsible for providing independents audits and audit related services including:

1) Internal audits of DPHHS financial management, compliance with State and Federal laws, the efficiency and internal controls of information systems and program performance.
2) Limited scope audits of DPHHS contractors to ensure good financial management and compliance with State and Federal laws.
3) Fraud audits as requested. The bureau works with criminal investigators and makes sure State and Federal funds are repaid.
4) Reviews of single audits to provide DPHHS program managers with information about contractors' financial management and compliance with program requirements.
5) Special request audits that compare costs to rates paid, ensure proper implementation of Federal and State programs, and contract compliance.

The Audit Bureau reports to the department director, but the bureau is located in the Quality Assurance Division for personnel management purposes. This reporting structure ensures the bureau's independence.

The Audit Bureau consists of six auditors and one bureau chief. Two auditors are CPAs, and one auditor is a Certified Fraud Examiner.

The DPHHS Audit Bureau has existed for at least 20 years, providing single audits and limited scope audits of DPHHS contractors. The department added the internal audit function in FY 2001. The Audit Bureau is actively involved with preventing and pursuing fraud.

Audits are requested by DPHHS divisions and the Audit Bureau initiates internal audits after conducting risk assessments. Fraud audits originate as requests from DPHHS divisions, they result from routine bureau audits, and they come from the Fraud, Waste and Abuse Hotline calls. Audit projects are performed according to the yearly work plan.

The Audit Bureau currently does audits for the Disability Services Division, the Addictive and Mental Disorders Division, the Health Resources Division, and the Business and Financial Services Division. Other divisions request audits as needed and the audit plan is adjusted accordingly.

#2

Attachment A

AUDIT BUREAU MAJOR ACCOMPLISHMENTS

Detection of Fraud – Two major fraud audits. The first fraud audit resulted in sentencing the perpetrator to 4.5 years in a federal penitentiary and restitution of $206,000. The second audit did not result in criminal charges, but the perpetrator terminated employment, and the organization repaid $155,471.55.

Internal Audits – Eleven audits of DPHHS internal work processes, analysis of costs versus rates paid, funds management guidance, and analysis of DPHHS electronic systems.

Agreed Upon Procedures Audits – Thirty-two audits of DPHHS contractors to ensure good financial management and compliance with State and Federal laws. Twenty-eight additional audits of small child care centers.

Review of A-133 Audits – Tracking and review of approximately 90 single audits of DPHHS contractors each year. Analysis of the audit results sent to DPHHS program managers to use for program management.

Contractor Financial Analysis to DPHHS Management – Financial ratio analysis of DPHHS contractors provided to DPHHS management.

Attachment B

CERTIFICATION BUREAU
2009 LEGISLATIVE SESSION FACT SHEET

The mission of the Medicare and Medicaid Survey and Certification (S&C) Program is to assure basic levels of quality and safety for Medicare and Medicaid beneficiaries. This is accomplished by contracting with State Agencies to conduct onsite, objective and outcome-based verification that basic standards of quality are being met by health care providers. The Certification Bureau within the Quality Assurance Division is the Montana State Survey Agency charged with these responsibilities. More than 400 various types of health care facilities in the state participate in the Medicare and Medicaid programs which are subject to oversight by the Certification Bureau.

Each of these facility types have specific time frames established by the Centers for Medicare and Medicaid Services (CMS) for conducting the onsite surveys by qualified staff. Adherence to these time frames is strictly scrutinized by CMS in their annual performance review of each agency. Examples of the time frames are:

- Long Term Care Facilities (nursing homes) – 15 month maximum interval with a 12 month average.
- Intermediate Care Facility for the Mentally Retarded – 12 month maximum interval.
- Home Health Agencies – 36 month maximum interval with a 24 month average.
- Accredited Hospitals – at the direction of CMS.
- Non-Accredited Hospitals – 5 year maximum with a 3 year average (this represents an increase in frequency for this biennium).
- End Stage Renal Disease Facilities – 10% sample selected by CMS annually with a 3 year average.
- Ambulatory Surgical Centers, Rural Health Clinics, Hospice, and Out Patient Physical Therapists – 5% sample selected by CMS annually, 6 year average.
- Psychiatric Residential Treatment Facility (PRTF) – 5 year average.

Based on the survey frequency of each provider type, the work load for FY 2008 completed by the Certification Bureau is as follows:

Provider Types	Facility Count	Initial Visits	Resurvey Visits	Follow-Up Visits	Complaint Visits	Total Visits
Long Term Care (LTC)	91	0	181	85	64	330
Intermediate Care Facility/Mental Retardation (ICF/MR)	1	0	2		1	3
Accredited Hospital	10	0	5	2	9	16
Non-Accredited Hospital	7	0	3	1	8	12
Critical Access Hospital (CAH)	45	2	27	13	8	50
Non-Accredited Home Health (HHA)	34	0	18	1	1	20
Hospice	2		1		0	1
Rural Health Clinic (RHC)	45	1	5	5	2	13
Ambulatory Surgical Center (ASC)	15	0	6		0	6
End Stage Renal Dialysis (ESRD)	12	0	1	2	0	3
Psychiatric Residential Treatment Facility	3	0	1	1	1	3
Outpatient Physical Therapy	1	0	0	0	0	0
TOTALS	266	3	250	110	94	457

In addition to the standard surveys conducted by the Certification Bureau, complaints and incidents of suspected abuse received by the Bureau regarding any of the provider types are logged into a CMS computer data base system. These complaints and incidents are tracked by CMS for adherence to specific criteria for data entry, prioritizing the complaint for onsite investigation and reporting any deficiencies cited.

The bureau is also responsible for oversight of medical laboratories in accordance with the Clinical Laboratory Improvement Amendments (CLIA).

The CLIA program is responsible for processing applications, maintaining a data base and provider information services for 681 labs in Montana. The CLIA surveyor conducts on-site surveys of 92 moderate and high complexity labs semi-annually as well as 2% of Certificate of Waiver Labs (7) and 1 or more accredited labs as assigned by CMS on an annual basis. This surveyor also conducts desk audits of proficiency testing for 120 labs across the state.

The Certification Bureau is also involved in the ongoing education and training of health care workers (professionals) throughout the state in two separate programs.

The Nurse Aide Training Program: Responsible for approving and monitoring 37 individual Nurse Aide Training Programs conducted by private contractors, health care facilities, or educational systems such as universities or vocational/technical training institutions. The Nurse Aide Registry had 10,094 individuals listed as certified nurse aides as of 12/05/2008. These individuals must be recertified every 2 years in accordance with requirements of the program. In the past year, the data management system, as well as the nurse aide training and competency testing program have been revised and updated.

Resident Assessment Instrument (RAI) Training: The resident assessment process required for nursing homes and hospital swing beds uses a computerized tool (Minimum Data Set or MDS) for identifying individual resident needs and for Medicare reimbursement. This data is transmitted to the state data base and is being used by the Quality Improvement Organizations for provider training and by the provider for their own quality improvement activities, and by CMS for the federal nursing home compare site. The Bureau is charged with providing training for the providers and state agency survey staff in the use of this assessment tool and patient care planning process. This training is accomplished by monthly telephone conference calls, individual consultation with provider staff by phone or email.

CERTIFICATION BUREAU MAJOR ACCOMPLISHMENTS

The Certification Bureau updated the Certified Nurse Aide (CNA) electronic registry on the state's website to make it user friendly. In addition, the CNA registry was made available to individuals using the state's Licensee Look-up feature on mt.gov. This feature interacts with other state agencies (DLI, DOC, and OPI) to list details of individuals who hold professional licenses in Montana.

Met Federal Performance Standards for nursing homes on:

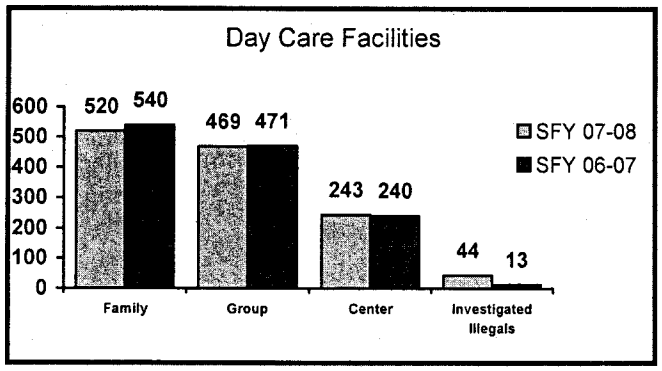
- Frequency of data entry;
- Documentation of survey deficiencies;
- Timeliness of EMTALA investigations; and
- Adherence to conditions of participation.

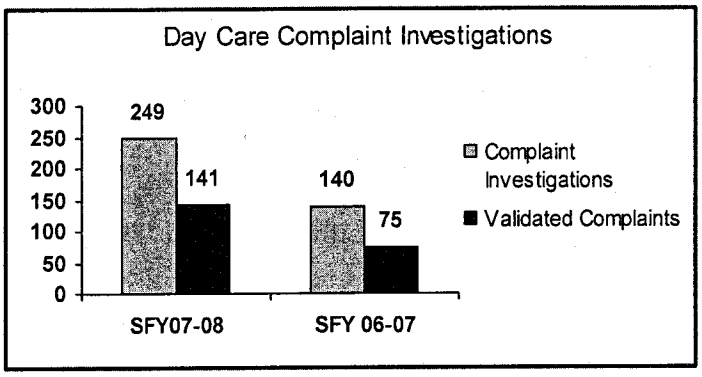
Attachment C

LICENSURE BUREAU
2009 LEGISLATIVE SESSION FACT SHEET

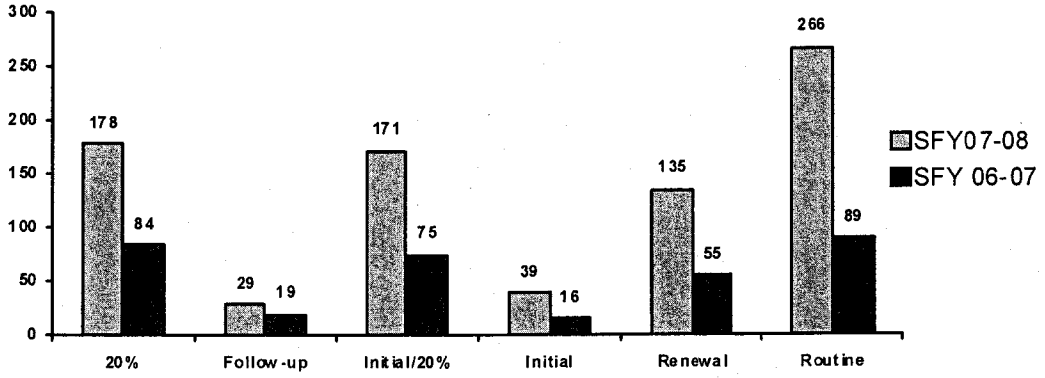
The Licensure Bureau is responsible for the development, enforcement and revision of state licensing rules to assure the public safety and welfare in approximately 716 of health care facilities, 342 Community Residential facilities and 1232 child day care facilities. Duties of the bureau include: licensure of new facilities, on-site inspections, investigations of complaints, taking enforcement action against non-compliant or unlicensed facilities; providing consultation and technical assistance to providers and applicants. All of these duties are performed by a total of 28 FTE.

Child Care Licensing Program





Day Care Inspections Conducted



Health Care Facility Information

Facility Type	Number	Facility Type	Number	Facility Type	Number
Approved CD	29	CD Trans. Living Cntrs	1	Infirmary	5
Adult Day Care	61	End Stage Renal Dialysis	12*	Long Term Care	92*
Adult Foster Home	96	Home Health Agency	41*	Mental Health Centers	18
Assisted Living	180	Home Infusion Therapy	14*	Out Pt Center Primary Care	8
Ambulatory. Surgical Center	15*	Hospital	17*	Behavioral Health	2
Critical Access Hospital	45*	Hospice	35*	Residential Treatment	3
Chemical Dep. Center	9	ICF-DD	1	Retirement Home	30
				Specialty Mental Health	2

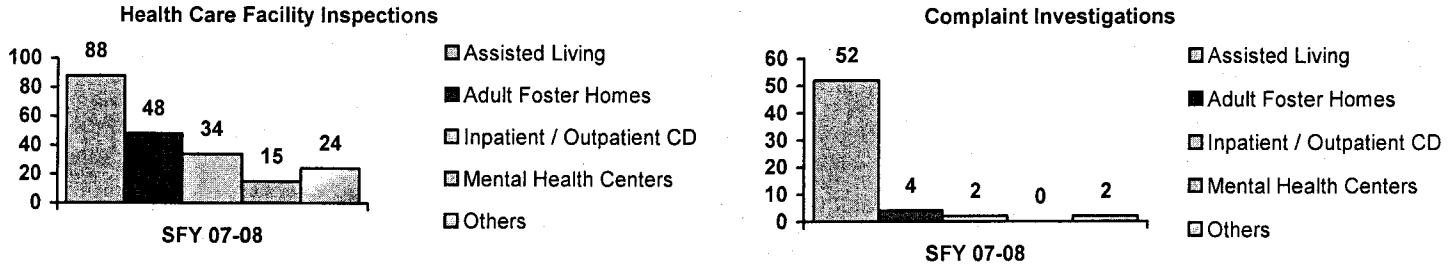
Total Number of Health Care Facilities 716

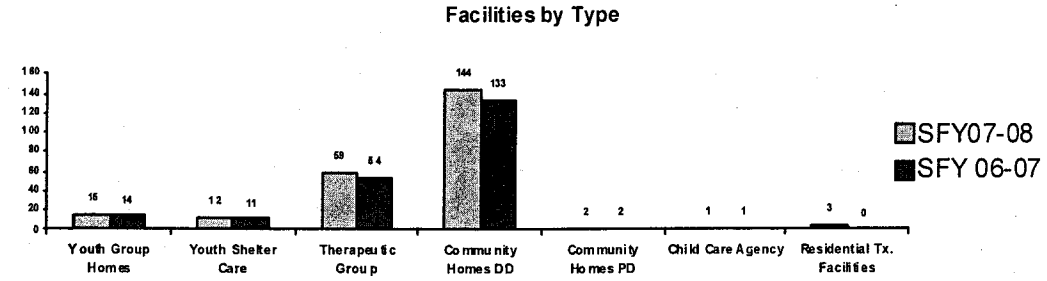
* Denotes certified facilities. Many of these facilities are surveyed by the Certification Bureau.

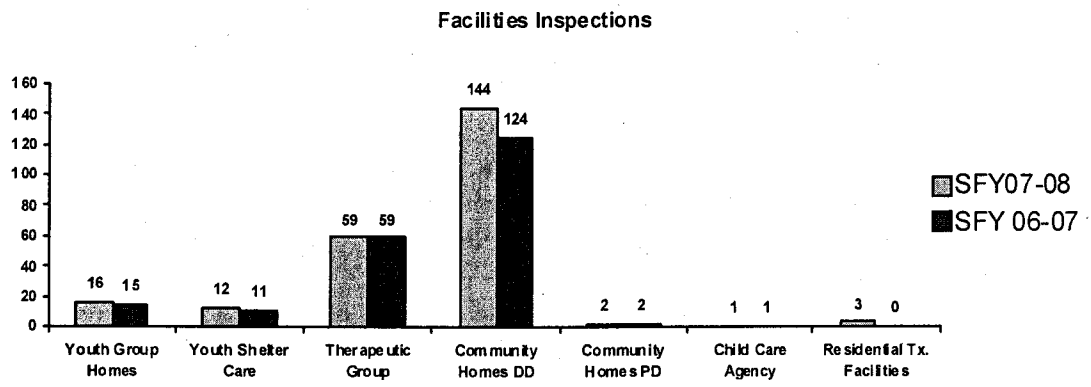
February 2009

Provisional Licenses Issued	FY08	FY07
Pending Survey/New Facility	10	71
Added Endorsements/Change of Ownership	31	
Administrative Action	4	7

Community Residential Treatment Program







LICENSURE BUREAU MAJOR ACCOMPLISHMENTS

- An overview showed that in FY08 the child care licensing program conducted 349 20% inspections which are mandated by state law. The program was only required to conduct 182.
- During FY07 the Child Care Licensing Program (CCLP) fully implemented phase I of the use of portable tablet computers for inspection purposes. In FY08, the CCLP has continued its work on the creation of a Public Web Portal which will enable parents and members of the general public to access the results of provider inspections.
- Health Care Facilities (HCF) Licensing Program decreased the number of provisional licenses in FY08 by 38.
- HCF continued efforts to refine the Complaint Tracking System; majority of complaint investigations are now being performed by State survey staff vs. contracted staff.
- Major overhaul of the Youth Care Facility rule has begun. Licensure Bureau is engaging in a negotiated rule making process with providers. Bureau anticipates the completion and implementation of this new rule to occur the end of FY09-beginning of FY10.

Attachment D

OFFICE OF FAIR HEARINGS
2009 LEGISLATIVE SESSION FACT SHEET

The purpose of the Office of Fair Hearings (OFH) is to assure due process by conducting fair, timely and impartial hearings and decisions under the Montana Administrative Procedures Act (MAPA) by applying federal and state laws and administrative rules to cases in which Claimants dispute actions or decisions in Department-administered programs. The Office of Fair Hearings does not adjudicate child support issues.

Hearing Officers independently render written legal decisions comprised of findings of fact, conclusions of law, and orders which are final and legally binding on the parties unless appealed to the Board of Public Assistance, the DPHHS Director, or a District Court, as applicable.

TIMEFRAMES FOR DECISIONS

Food Stamps:	60 days after receipt of hearing request
ADH Food Stamps:	90 days after date of scheduling letter
TANF Cash Assistance:	90 days after receipt of hearing request
Medicaid Applicants/Recipients:	90 days after receipt of hearing request
Medicaid Providers:	90 days after submission of case to Hearing Officer
Informal Dispute Resolution: (nursing care facilities):	60 days after final submission of documents to Hearing Officer
All Others:	90 days after submission of case to Hearing Officer unless extended 30 days for "good cause shown."

Fair Hearing Inventory – Year to Date 12/31/08

SFY	Hearing Requests	Requests Withdrawn Resolved at AR	Hearing Decisions	Decisions Timely	Percent Timely	Hearings Outstanding
2003	830	396	433	323	75%	1
2004	826	423	401	318	79%	1
2005	968	548	418	347	83%	2
2006	1172	618	553	503	91%	1
2007	1099	558	537	523	97%	4
2008	1077	581	482	472	98%	17
2009	497	232	125	122	98%	138

Note: Based upon the date/year hearing received.

Attachment D

Fair Hearing Decision Production by Fiscal Year

SFY	Hearing Decisions	Decisions Timely	Percent Timely
2003	450	308	68%
2004	376	303	81%
2005	403	314	78%
2006	545	497	91%
2007	583	537	92%
2008	529	516	98%
2009	204	196	96%

Note: Based upon date decisions rendered during July-June each year regardless of the date/year received.

Informal Dispute Resolutions (IDR) Year to Date 12/31/08

Calendar Year	IDRs Requested	IDRs Withdrawn or Denied	IDR Opinions	Timely Rendered	Percent Timely
2005	20	2	18	5	28%
2006	24	9	15	13	87%
2007	19	8	11	10	91%
2008 *	13	3	8	3	37.5%*

* Of the two cases outstanding for 2008, one case has been closed in accordance with the timelines and as of February 2008 one case remains outstanding. This case is expected to be timely.

MAJOR ACCOMPLISHMENTS

Completed the construction of the OFH website to which all final hearing decisions are posted for public access. This website can be searched by year, program, and issue for obtaining de-identified hearing decisions for purposes of research and information. This website is a useful tool for clients, providers, attorneys and agency staff as a resource for information and resulted in administrative efficiencies in the Office of Fair Hearings. The on-line availability eliminates the need to submit written requests for information on a specific case or group of cases and the administrative requirements to respond to those requests. This results in administrative savings and efficiency for the office and a useful resource for the public.

The Office of Fair Hearings utilizes an automated case management system known as HITS (Hearing Information Tracking System) that tracks cases, caseload assignment, and resolution of cases. This system is used to generate data needed to track and monitor timeliness of decisions. During SFY 2008 the office attained a timeliness percentage of 98% for Fair Hearing Decisions. In recognition of this effort, the Supplemental Nutrition Assistance Program (SNAP) lifted the reporting requirement under a corrective action plan pertaining to SNAP hearing decisions.

Attachment E

PROGRAM COMPLIANCE BUREAU
2009 LEGISLATIVE SESSION FACT SHEET

Surveillance and Utilization Review Section (SURS)

- Responsible for ensuring the integrity of the Medicaid claim payments.
- Functions are accomplished through the following activities:
  - Working with fiscal intermediary to ensure sanctioned providers are not participating in the Medicaid program.
  - Data analysis and statistical review of billing practices of Medicaid providers.
  - Perform retrospective claim reviews of Medicaid providers with aberrant billing practices. Reviews can result in overpayment recoveries and providers receive education on best practices and applicable resources that they can utilize.
  - Coordinating administrative rule and provider manual changes with the appropriate Medicaid programs and divisions, to ensure payments are made accurately.

Program Compliance/PERM Section

- Responsible for performing quality control reviews of the Medicaid, CHIP and Food Stamp programs.
- Functions are accomplished through the following activities:
  - Review of selected cases by random sample for Food Stamps, Medicaid, and CHIP eligibility, using knowledge of the programs and audit techniques to assess the accuracy of the eligibility determination.
  - Coordination of PERM claim audits conducted by CMS contractors.

Claims and Investigation Section

- Responsible for investigation of Intentional Program Violations (IPV) by recipients, and the management and collection of overpayment recoveries from recipients.
- Functions are accomplished through the following activities:
  - Investigate potential cases of recipient Intentional Program Violation (IPV) received from county OPA workers and/or from general citizens on the referral hotlines.
  - Manage and establishment and collection of client overpayments.

Third Party Liability (TPL)

- Responsible for ensuring that Medicaid is the payer of last resort.
- Functions are accomplished through the following activities:
  - Coordination of benefits with Medicare and other health insurance.
  - Operating the Medicare buy-in program to pay for Medicare premiums and coordination of Part D benefits and clawback payments for eligible low-income senior citizens.
  - Operating the Health Insurance Premium Payment program for Medicaid recipients who need assistance in maintaining their health insurance.
  - Collection of Medicaid funds from other insurance, settlements, liens, estates and other sources of funding.

HIPAA Privacy

- Responsible for ensuring the departments compliance with the privacy aspects of HIPAA.

Attachment E

MAJOR ACCOMPLISHMENTS

Surveillance and Utilization Review Section (SURS)

Completed 665 provider reviews during State fiscal years 2007 and 2008. The SURS unit recovered over $1,500,000 in overpayments from providers during State fiscal years 2007 and 2008.

Program Compliance/PERM Section

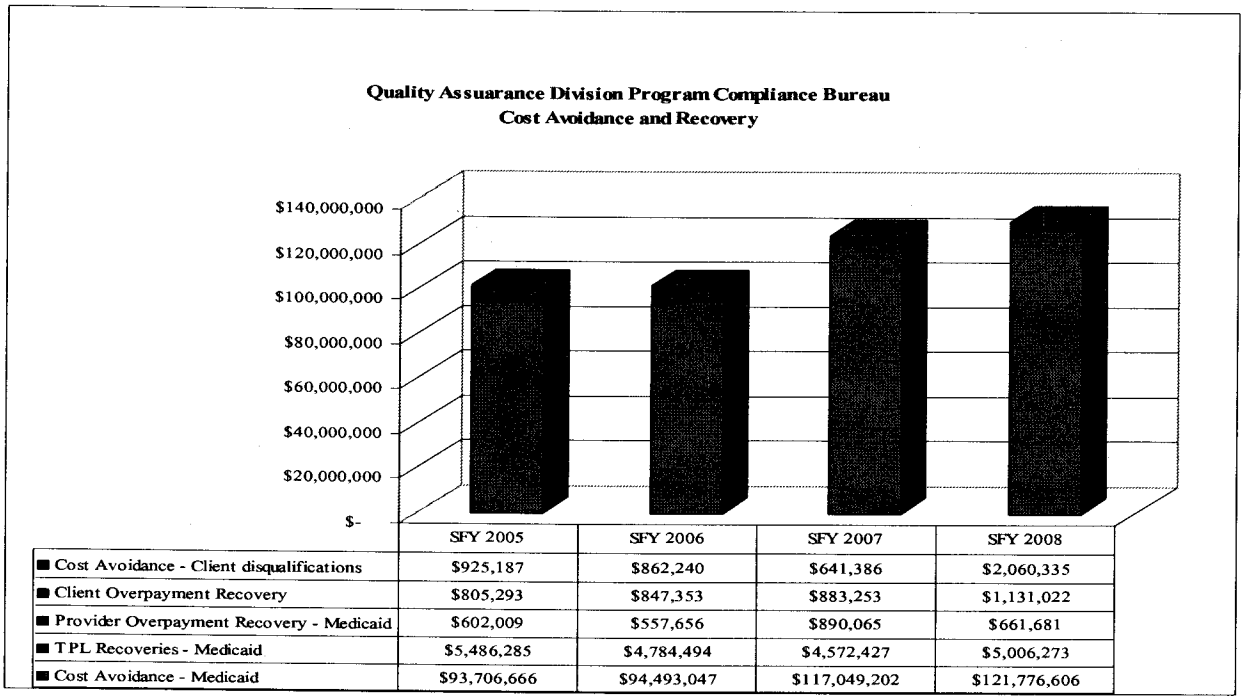
- Implemented PERM eligibility and claim audits. Conducted all PERM eligibility reviews as required by CMS.
- For State Fiscal Years 2007 and 2008 reviewed over 2,457 SNAP cases and 1,236 Medicaid cases.
- Submitted claims to CMS contractors for audits, and began to work with contractors to conduct these audits.

Claims and Investigation Section

During State Fiscal Years 2007 and 2008 received 1,449 Intentional Program Violation (IPV) referrals for investigation. Investigations resulted in over $2,700,000 in savings for SNAP (Food Stamp) due to client disqualifications. In addition, the unit collected over $2,000,000 from recipients in overpayments in the SNAP, Medicaid and TANF programs.

Third Party Liability (TPL)

TPL completed numerous system and procedural changes that improved the accuracy and timeliness of activities. Through automation and efficiency the section increased savings for Medicaid by $27,500,000 from SFY 2006 to 2008.



	SFY 2005	SFY 2006	SFY 2007	SFY 2008
Cost Avoidance - Client disqualifications	$925,187	$862,240	$641,386	$2,060,335
Client Overpayment Recovery	$805,293	$847,353	$883,253	$1,131,022
Provider Overpayment Recovery - Medicaid	$602,009	$557,656	$890,065	$661,681
TPL Recoveries - Medicaid	$5,486,285	$4,784,494	$4,572,427	$5,006,273
Cost Avoidance - Medicaid	$93,706,666	$94,493,047	$117,049,202	$121,776,606

EXHIBIT 2
DATE 2/12/09
HB 2

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Brian Schweitzer
GOVERNOR

Anna Whiting Sorrell
DIRECTOR

STATE OF MONTANA

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To: Health and Human Services Subcommittee
Representative Teresa Henry, Chair

From: Quality Assurance Division

Date: January 23, 2009

Re: Questions from the Subcommittee on vacancy savings and retirement

Question #1 **How many positions are vacant now (January 2009) and what do they do? Why are they open? Which of these positions are held open to meet vacancy savings?**

This table provides the answers to all of the questions. This data is as of January 15, 2009

QAD	Advertised	Third Party Liab Finan Exam	1.00
	Filled	Health Facility Surveyor	6.00
	Interviewing	Administrative Assistant	1.00
		Compliance Specialist	1.00
	OTO Position	Third Party Liab Supervisor	0.50
	Under review	Resid Care Licensing Surveyor	1.00
	Vacancy Savings	Resid Care Licensing Surveyor	1.00
QAD Total			11.50

Question #2 **How many positions would have to be held open to make the 4 percent vacancy savings? (Annual number) What groups of positions are most likely to be open and what do they do? See LFD Analysis, page B-152.**

FY09
120.45 FTE X 4% = 4.82 FTE (Based on the assumption that all FTE are funded proportionally)

(Page B-152) – The vacancy report states that facility surveyors and compliance specialists have historically experienced high turnover. Although positions are general advertised once notice is received it does result in extra workload for other staff. Of the 11.50 positions that are currently vacant; these positions make up 78% of the current vacancies.

Question #3 **What is the division's total 7 percent vacancy savings and how many positions would have to be held open to make the 7 percent vacancy savings? What additional positions (by group) are most likely to be open and what do they do? List only the additions to the 4 percent list.**

FY09
120.45 FTE X 7% = 8.43 FTE (Based on the assumption that all FTE are funded proportionally)

#2

Additional open positions needed to achieve the 7% vacancy savings will likely be similar or the same types of positions as those listed in response to Question #2 above.

Question #4 **Of the division's anticipated retirements, what positions do the retirees hold? Is the estimated payout still in line with the estimates on page B-4 of the LFD Analysis?**

The division's employees eligible for retirement benefits based on projections using the data provided by DOA are 78 FTE for the biennium. The anticipated compensated absence liability of $114,072 is still in line with the estimates on page B-4 of the LFD analysis. The following table shows the retirements that have occurred in the past two fiscal years in general job categories.

Management/Supervisor Pay Bands (5,6,7)	17%
Professional/Program Pay Bands (5,6,7)	83%
	100%

Question #5 **Would the division make cuts in the operating budget to meet vacancy savings? Please identify.**

If needed to achieve the target amount of vacancy savings, the division can consider reductions in travel, training, equipment purchases and other discretionary operating costs. All operating budget reductions for this purpose will be subject to the review and approval of the agency senior management team in light of overall agency priorities.

The division has already submitted a 5% Reduction Plan to the OBPP in preparation for the 2009 session which will be used to guide the initial division fiscal reductions if it becomes necessary.

Question #6 **If the division should have to make cuts to services, which services would be reduced first? Does the division have the authority to eliminate any programs during the interim? Please list the programs.**

Elimination of programs and services is not at the discretion of the division. If program or services reductions are required, the DPHHS senior management team will assess the agency priorities, critical service needs, federal and state mandates, as well as fiscal targets, and make recommendations to the Governor for his consideration.

Attachment F

MEDICAL MARIJUANA PROGRAM (MMP)
2009 LEGISLATIVE SESSION FACT SHEET

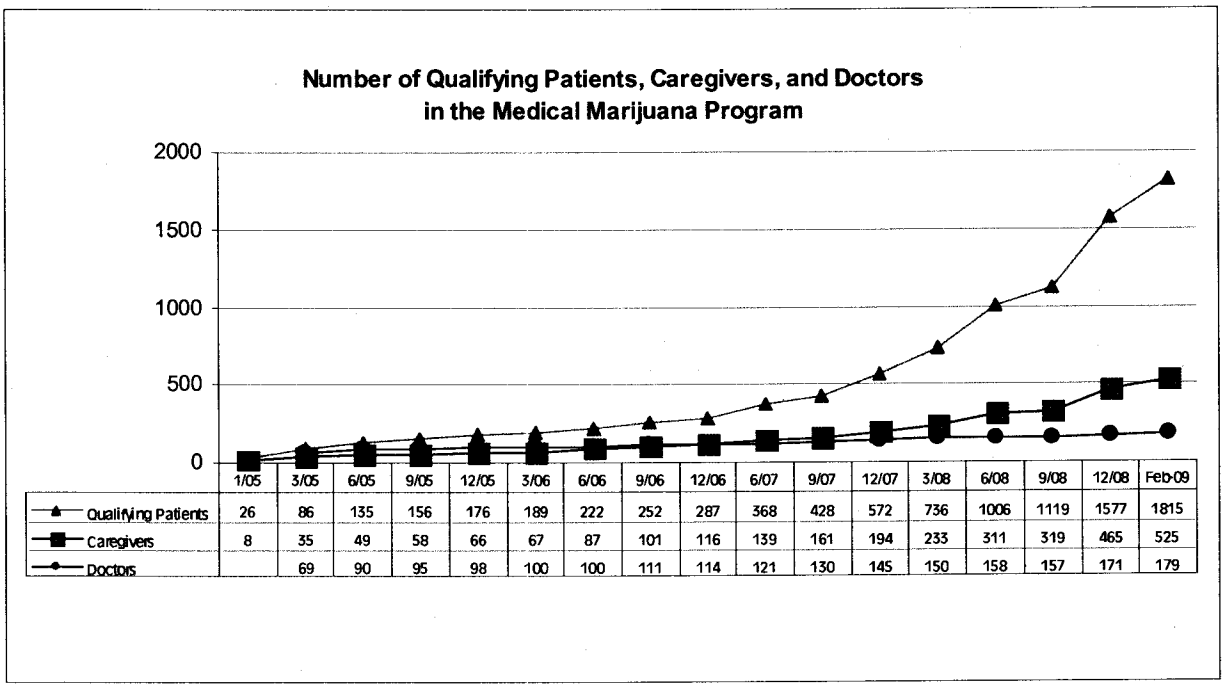
Pursuant to 50-46-103(9), MCA, the department shall report annually to the legislature the number of applications for registry identification cards, the number of qualifying patients and caregivers approved, the nature of the debilitating medical conditions of the qualifying patients, the number of registry identification cards revoked, and the number of physicians providing written certification for qualifying patients. The department may not provide any identifying information of qualifying patients, caregivers, or physicians.

On January 21, 2005, the first Medical Marijuana Program (MMP) registry identification cards were issued to 26 qualifying patients and eight caregivers. Currently the program has 1815 qualifying patients on the registry. As of December 31, 2008, the following information is provided as required for the MMP:

- 1577 approved qualifying patients
- 465 approved registered caregivers
- 1 minor approved
- 171 physicians providing written certification for qualifying patients
- 42 counties with qualifying patients
- 2 registry identification cards revoked
- 10 qualifying patients have died
- 140 qualifying patient cards have lapsed, (not renewed)

One hundred twenty-six of the 465 caregivers have more than one qualifying patient. These 126 caregivers serve 837 qualifying patients or 53% of the registry's patients.

Percentage increases in the Medical Marijuana Program between 2005 and 2008 have risen steadily. Since the 2007 legislative session report, the number of doctors certifying the benefits of the use of medical marijuana has increased by 50%, the number of caregivers has increased by 300%, and the number of approved qualifying patients has increased by 449%. See graph below:

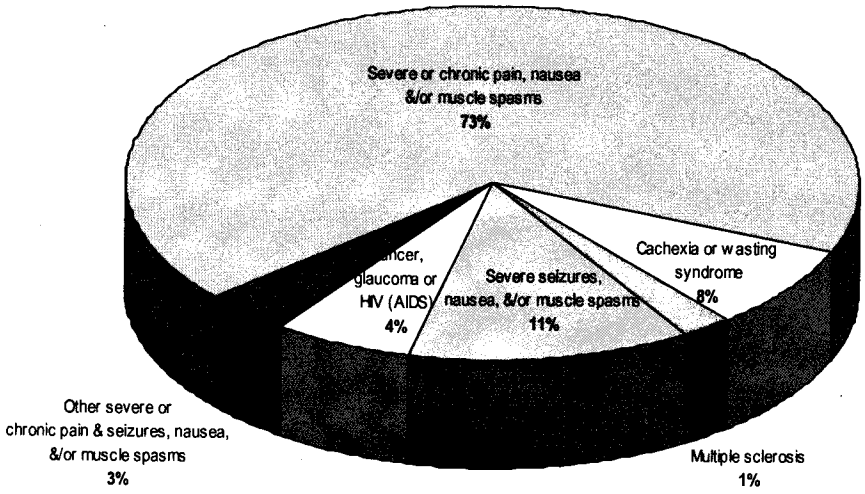


	1/05	3/05	6/05	9/05	12/05	3/06	6/06	9/06	12/06	6/07	9/07	12/07	3/08	6/08	9/08	12/08	Feb-09
Qualifying Patients	26	86	135	156	176	189	222	252	287	368	428	572	736	1006	1119	1577	1815
Caregivers	8	35	49	58	66	67	87	101	116	139	161	194	233	311	319	465	525
Doctors		69	90	95	98	100	100	111	114	121	130	145	150	158	157	171	179

February 2009

Attachment F

Predominate Medical Condition



Predominate Medical Condition	Qualifying Patients	Qualifying Patients Percentage
Multiple sclerosis	20	1%
Severe seizures, nausea, &/or muscle spasms	181	11%
Cancer, glaucoma or HIV (AIDS)	63	4%
Other severe or chronic pain & seizures, nausea, &/or muscle spasms	43	3%
Severe or chronic pain, nausea &/or muscle spasms	1150	73%
Cachexia or wasting syndrome	120	8%
Totals	1577	100%

The registration fee charged to qualifying patients is based on program costs. The registration fee has reduced since the inception of the MMP, but has remained at $50.00 over the last few years. The Department does not anticipate a fee adjustment will be required prior to FY 09.

Effective Date	MMP Registration Fee
1/1/05	$200.00
7/1/05	100.00
7/1/06	50.00
7/1/07	50.00
7/1/08	50.00

The MMP is experiencing significant growth in the number of approved patients and caregivers and this is expected to continue into the next biennium. To keep up with this increased demand QAD is requesting an additional 0.50 FTE for the administration of the program to address the increased workload.

Attachment G

PAYMENT ERROR RATE MEASUREMENT (PERM)
2009 LEGISLATIVE SESSION FACT SHEET

Background Information & Progress

During the 2007 legislative session the department requested funding to implement the federally required PERM audits. The Department of Public Health and Human Services (DPHHS) operates the Medicaid program, and is required to complete PERM audits as required by the Centers for Medicare and Medicaid Services (CMS). Below is a summary of the key points of PERM:

- Federal Mandate.
- States will be reviewed every three years; Montana is Federal Fiscal Year 2008 and 2011.
- Review Medicaid and SCHIP separate.
- Federal contractors will review 1000 claims for Medicaid and SCHIP, each.
- States will review 500 active eligibility cases and 200 inactive for Medicaid and SCHIP, each.
- The error rates will not result in recoveries or overpayments, except for specific errors; therefore there are no significant savings that will be realized. There maybe individual claim adjustments, or possible process improvement changes.
- Costs will apply to the SCHIP administrative cost cap.

DPHHS has successfully implemented PERM for FFY 2008 and has completed 1,416 eligibility reviews and all reviews will be reported to CMS by the federal deadline of April 30, 2009. In addition, DPHHS has submitted claims to CMS contractors, has held a number of planning sessions with the CMS contractors to prepare for the claim audits, and the CMS auditors are scheduled to be in Montana the last week of January and first week of February to begin their audits. It is anticipated these audits will be concluded by June 30, 2009.

The final error rate is a combination of the eligibility and claim errors. PERM results are published in the performance and accountability report published annually by the US Department of Health and Human Services in November 2009.

Next Steps

Montana's PERM year is federal fiscal year 2008 (October 1, 2007 – September 30, 2008).

The next PERM cycle is federal fiscal year 2011 (October 1, 2010 – September 30, 2011).

For the next biennium this PERM cycle encompasses approximately September 2010 through June 2011 or 10 months of fiscal year 2011. For budgeting purposes, DPHHS begins the PERM cycle one month prior to the PERM year to conduct training and planning for staff, as well as activities that are required for submitting and approval of sampling plans with CMS.

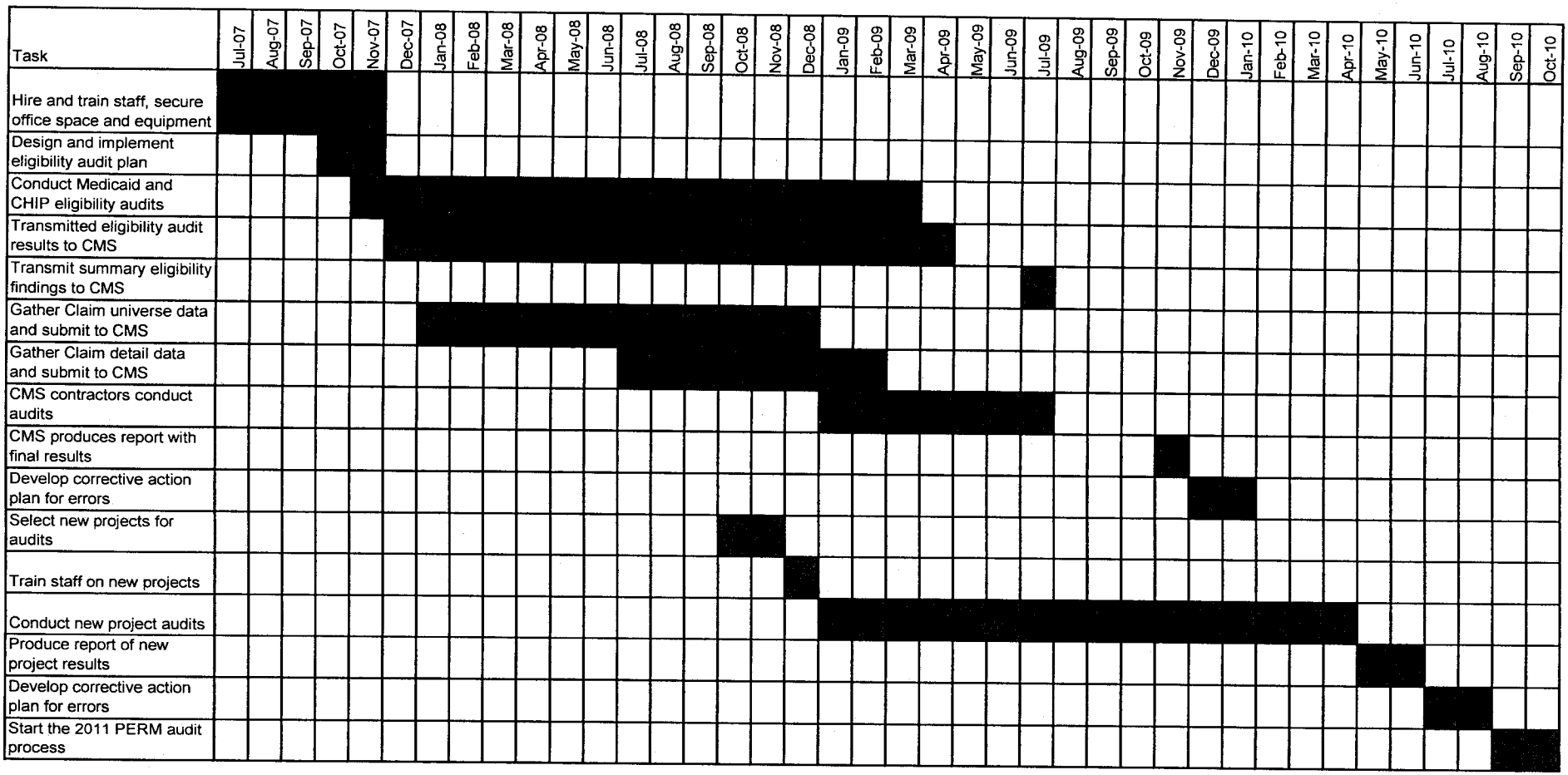
Therefore, for the beginning of the 2011 biennium until the beginning of the next PERM cycle (July 1, 2009 through approximately August 31, 2010), PERM staff will be working on special projects related to Medicaid. The proposed Medicaid focus in between PERM years includes conducting reviews of eligibility on three project areas:

- Nursing Home,
- Medically Needy/Incurment,
- and Developmental Disabilities cases.

QAD began the planning for these reviews in December 2008 and will begin the reviews in January 2009. During the 2007 session the PERM funding was discussed and approved by the legislature and included permanent full-time staff. During the non-PERM years the department was requested to utilize this staff to work on other special audits that may be high risk or involve significant expenditures.

Attachment G

Below is a summary of the significant milestones and their due dates:



Attachment H

LIEN AND ESTATE RECOVERY COSTS
2009 LEGISLATIVE SESSION FACT SHEET

During the 2007 legislative session the Quality Assurance Division (QAD) requested funding to pursue and resolve difficult and old Lien and Estate recovery cases, and the legislature funded this effort with one-time only funding. The QAD proposal to the 2009 legislature is to request a re-authorization of the funding for Lien and Estate cases.

The Department of Public Health and Human Services (DPHHS) operates the Medicaid program, a requirement of operating the Medicaid is that the State must operate a Lien and Estate recovery program. DPHHS operates its Lien and Estate recovery program under the authority of MCA sections 53-6-167 and 53-6-171.

The majority of the lien and estate recovery cases are handled on a very routine basis. However, there are instances (such as abandonment of property, no probate filings, title discrepancies, lack of heirs, back taxes, and other legal issues) that require legal assistance and potentially property repairs and payment of back taxes to resolve the cases. QAD has engaged the Department of Justice (DOJ) Agency Legal Services (ALS) to provide legal assistance to resolve more difficult cases, including the backlog of cases from the previous contractor.

On a pilot basis QAD began this project in State Fiscal Year 2007 and expanded those efforts once funding was received. Below is a summary of the activity and collections as of December 31, 2008 on cases that have been referred to DOJ ALS:

Fiscal year case was resolved	# of old cases referred (see note 1)	# of new cases referred (see note 2)	# of cases closed	Amount recovered (see note 3)
SFY 2007		29	29	$547,228
SFY 2008	35	18	53	$616,539
SFY 2009 *	11	8	19	$315,967
Still Open	41	12	2 interim collections	$16,434
Total	87	67	103	$1,496,168

* Thru 10/31/08

Note 1 – Old cases refer to cases that were handled a previous contractor and taken over by QAD, these cases were taken over July 1, 2004.

Note 2 – New case refer to cases that were started by QAD after taken over the Lien and Estate duties July 1, 2004.

Note 3 – Montana returns to the Federal Govt the FMAP, and retains the balance as state special revenue.

QAD has expended $279,023 from the beginning of this project to recover these funds, $214,419 in legal and probate expenses and $64,605 in other expenses (i.e. back taxes, property maintenance). In conjunction with DOJ, QAD has closed 103 cases under this project.

Attachment H

Below is a summary of the expenses per case closed and the amount recovered compared to our original estimates presented to the 2007 legislature.

	Actual	Estimate
Recovery per closed case	$14,526	$20,000
Cost per closed case	$1,962	$4,577

The actual recovery case is lower than our original estimate because a number of the old estates did not have any funds available for recovery.

As of December 31, 2008 QAD has 53 cases still open and outstanding with DOJ, and approximately 20 cases that will require additional legal assistance that have not yet been referred to DOJ.

Important note to reader: DPHHS does not file liens on any property except real property, and only for Medicaid recipients who are permanently residing in a nursing home, and who do not have residing in the house 1) a spouse, 2) dependent child who is under 21 years of age, blind, or permanently and totally disabled, or 3) sibling who was residing in the recipient's home for a period of at least 18 months immediately prior to the recipient's institutionalization.